diem rate for the service category multiplied by the number of days covered by the bill plus the full appropriate ancillary rate as calculated in Section III.E.

(2) Sixty days after a patient reaches outlier status, monthly thereafter, and upon discharge, a facility shall bill the Department for charges in excess of the outlier threshold. The facility shall also document to the Department's reasonable satisfaction the medical necessity for the days of care and services rendered. The Department shall pay such bills that are appropriately documented and properly within the scope of the acute care Medicaid program no less than quarterly. The Department shall pay for the full per diem and 80% of the ancillary charges, excluding amounts included in computing the Outlier Threshold. At the next Rebasing, the Department shall calculate a new percentage of ancillary charges that it will pay for Outlier Claims based upon the statewide weighted average ancillary cost to charge ratio.

2. For the purpose of determining Capital Related Costs associated with outlier cases, the full amount of charges shall be included in the facility's computation.

E. PAYMENT FOR SERVICES RENDERED TO PATIENTS WITH OTHER HEALTH INSURANCE

Medicaid is a secondary payor. In no case will Medicaid pay a sum, when considered in conjunction with payments from all other sources (including the patients cost share and Medicare), that exceeds the amount that would have been paid if no other source of reimbursement existed.

F. LIMITATIONS ON ACUTE CARE FACILITY PAYMENT

1. Calculation of the prospective payment rate shall not be affected by a public provider's imposition of nominal charges in accordance with federal regulations. However, for providers whose charges are less than costs on the most recently filed cost report and who do not qualify as a nominal charge provider, the prospective rate shall be reduced during the interim until the applicable cost report is filed and a settlement adjustment made in accordance with Section I.C.2. The interim reduction shall be in proportion to the ratio of costs to charges on the most recent filed cost report. Updated data and charge structures may be provided to the state's fiscal intermediary if the provider believes its rate structure has changed significantly since the most recent filed cost report. But the state will be responsible for approving the final interim rate reduction necessary to approximate final settlement as closely as possible.

2. Payment for out-of-state acute care facility services shall be the lesser of the facility's charge the other state's Medicaid rate, or the weighted average Hawaii Medicaid rate applicable to services provided in comparable Hawaii facilities.

3. The Department or its utilization review agent may deny full or partial payment if it is determined that the admission or transfer was not medically necessary or the diagnosis or procedure code was not correctly assigned, or the patient was retained in the facility longer than necessary. The Department shall recovery amounts due using the most expedient methods possible, which shall Include but not be limited to off setting amounts against current payments due providers.

V. CHANGES TO PROSPECTIVE PAYMENT RATES

A. ADJUSTMENTS TO BASE YEAR COST DUE TO AUDIT OR APPEAL OF AUDIT ADJUSTMENT

1. Changes subsequent to the initial determination of Base Year rates due to an audit of contracted services data reported on the provider's survey,

or due to appeals of audit and adjustment made to costs reported on the based year cost report, shall not result in changes to the rate ceiling or classification group.

2. Base Year costs shall be adjusted to reflect the audit and appeal decisions, and the facility's specific prospective rates (including the impact of all adjustment factors) and reimbursement for Capital Related Costs rate shall be recalculated, effective the first day of the initial rate year in which those costs were used to compute the PPS rate, based on the adjusted Base Year cost, as long as the rate ceilings are not exceeded.

B. REBASING THE PROSPECTIVE PAYMENT RATES

The Department shall perform a Rebasing periodically so that a Provider shall not have its Basic per Diem and Per Discharge Rates calculated by reference to the same Base Year for more than eight state fiscal years.

C. REQUESTS FOR RATE RECONSIDERATION

1. Acute care providers shall have the right to request a rate reconsideration if one of the following conditions has occurred since the Base Year:

a. Extraordinary circumstances, including but not limited to acts of God, changes in life and safety code requirements, changes in Licensure law, rules or regulations, significant changes in case mix or the nature of service, or addition or new services occurring subsequent to the Base Year. Mere inflation of costs, absent extraordinary circumstances, shall not be grounds for rate reconsideration.

b. Reduction in Medicaid average length of stay within a facility which produced a decrease in the average cost per discharge but an increase in the average cost per day. This paragraph shall not include reductions in average length of stay resulting from a change in case mix. The rate reconsideration

relief provided under this section shall be the lesser of actual growth in the cost per day since the Base Year or 75 percent of the reduction in the average cost per discharge (inflated) since the Base Year divided by the current average length of stay. In no case shall the add on exceed the actual ancillary and room and board costs of the facility.

c. The addition of an approved intern and resident teaching program. This is the only circumstance that is eligible for a rate reconsideration request by a New Provider.

2. A Provider may also obtain a rate reconsideration if it provides an atypically high percentage of special care, determined as follows. In order to obtain the relief, the Provider must meet each of the tests and follow each of the procedures defined below:

a. One or more of the facility's per diem rates is affected by the ceiling in its classification for that type of service;

b. The percentage of the facility's Base Year Medicaid special care days over total Base Year Medicaid days (excluding days that are reported in the nursery cost center on the cost report) is greater than 150% of the same average for all other facilities in its classification. The data to perform the comparison shall be obtained from the Base Year Medicaid cost reports;

c. The facility's average per diem costs for both general inpatient routine service and special care, excluding Capital Related Costs and medical education costs, are no greater than 120% of the weighted average for all other facilities in the same classification. The data to perform the comparison shall be obtained from the Base Year Medicaid cost reports;

d. The Provider must analyze its Base Year costs and vary its Special Care Percentage to determine its Breakeven Point. This analysis

shall be performed for each PPS rate that was affected by a component ceiling;

e. The Provider must compute its Special Care Percentage based upon the most recent information available;

f. The Provider must certify to the Department in conjunction with its rate reconsideration request that, based upon its most recently filed cost report, the percentage defined in subsection b. continues to exceed 150% of the average for all other facilities in its classification during the Base Year. The certification shall be based upon a cost report classification method that is consistent with the method that the facility used in the Base Year Medicaid cost report;

g. The Provider must submit the results of all of the foregoing analyses and calculations, along with its certification, to the Department as part of its rate reconsideration request. For each rate category in which the most recent Special Care Percentage exceeds the Breakeven Point, the Provider shall have the applicable PPS rate increased by the amount that was it was reduced due to the application of the component ceilings. For each rate category in which the most recent Special Care Percentage is equal to or less than the Breakeven Point, the Provider shall receive no increase in its PPS rates.

3. Requests for reconsideration shall be submitted in writing to the Department and shall set forth the reasons for the requests. Each request shall be accompanied by sufficient documentation to enable the Department to act upon the request. Documentation shall include the data necessary to demonstrate that the circumstances for which reconsideration is requested meet the requirements noted above. Documentation shall include the following:

a. A presentation of data to demonstrate reasons for the hospital's request for rate reconsideration.

b. If the reconsideration request is based on changes in patient mix, then the facility must document the change using diagnosis related group case-mix index or other well-established case-mix measures, accompanied by a showing of cost implications.

4. A request for reconsideration shall be submitted within 60 days after the prospective rate is provided to the facility by the Department or at other times throughout the year if the Department determines that extraordinary circumstances occurred. The addition of an approved intern and resident teaching program shall be one example of that type of extraordinary circumstance that justifies a mid-year rate reconsideration request.

5. The provider shall be notified of the Department's discretionary decision in writing within a reasonable time after receipt of the written request.

6. Pending the Department's decision on a request for rate reconsideration, the facility shall be paid the prospective payment rate initially determined by the Department. If the reconsideration request is granted, the resultant new prospective payment rate will be effective no earlier than the first date of the prospective rate year.

7. A provider may appeal the Department's decision on the rate reconsideration. The appeal shall be filed in accordance with the procedural requirements of Chapter 17-1321, administrative rules (see appendix to state plan).

8. Rate reconsiderations granted under this section shall be effective for the remainder of the prospective rate year. If the facility believes its experience justifies continuation of the rate in subsequent rate years, it shall submit information to update the documentation specified in subsection 2 within 60 days of

the notice of the facility's rate for each subsequent rate year. The Department shall review the documentation and notify the facility of its determination as described in subsection 4 above.

9. The Department may, at its discretion, grant a rate adjustment which is automatically renewable until the Base Year is recalculated.

10. Rate increases will be paid as a lump-sum amount.

VI. REPORTING REQUIREMENTS

A. COST REPORTING REQUIREMENTS

1. All participating acute care facilities shall maintain an accounting system which identifies costs in a manner that conforms to generally accepted accounting principles.

2. Participating facilities shall submit the following on an annual basis no later than 90 days after the close of each facility's fiscal year:

   a. Uniform Cost Report;

   b. Working Trial Balance;

   c. Provider Cost Report Questionnaire;

   d. Audited Financial Statements if available; and

   e. Disclosure of Appeal Items Included in the Cost Report.

3. Payment for services will be temporarily reduced by 20 percent if the cost report is not received within 120 days, and 100 percent if the cost report is not receive within 150 days. A 30-day maximum extension will be granted upon written request for good cause as provided in Medicare guidelines.

4. Each provider shall keep financial and statistical records of the cost reporting year for at least

five years after submitting the cost report to authorized State or federal representative.

B. AUDIT REQUIREMENTS

1. The Department or its fiscal agent shall conduct periodically either on-site or desk audits of cost reports, including financial and statistical records of a sample of participating Providers in each Provider classification.

2. Reports of the on-site or desk audit findings shall be retained by the Department for a period of not less than three years following the date of submission of the report.

3. Each Provider shall have the right to appeal audit findings in accordance with the procedural requirements of Chapter 17-1321 of the Hawaii Administrative Rules (see appendix to state plan).

VII. WAITLISTED PATIENTS

A. Payments for waitlisted patients shall reflect the level of care required by the patient. The facility shall receive a routine per diem for each day that a waitlisted patient remains in the acute care part of the facility. Room and board waitlisted rates are to be determined based upon the statewide weighted average costs of providing either Acuity Level A or C services by distinct part facilities per the Medicaid long term care prospective payment rate calculations with the following exceptions:

1. The waitlisted rates cannot exceed the facility's own distinct part Acuity Level A or C prospective payment rates.

2. A facility with a distinct part SNF, but no ICF, would have an Acuity Level A waitlisted rate based on the statewide weighted average (but not to exceed the facility's distinct Acuity Level C PPS rate).

3. In no case will any relief granted under rate reconsideration be used to adjust the waitlisted rates.

B. Waitlisted rates shall be annually adjusted by the same inflation factors as the long term care PPS rates.

C. In all cases, the payment rate under this Plan for Waitlisted long term care patients in acute care beds does not include ancillary services except for medical supplies and maintenance therapy. These excluded ancillary services must therefore be billed separately. Payments will be consistent with the ancillary rates paid to long-term care facilities.

or due to appeals of audit and adjustment made to costs reported on the based year cost report, shall not result in changes to the rate ceiling or classification group.

2. Base Year costs shall be adjusted to reflect the audit and appeal decisions, and the facility's specific prospective rates (including the impact of all adjustment factors) and reimbursement for Capital Related Costs rate shall be recalculated, effective the first day of the initial rate year in which those costs were used to compute the PPS rate, based on the adjusted Base Year cost, as long as the rate ceilings are not exceeded.

B. REBASING THE PROSPECTIVE PAYMENT RATES

The Department shall perform a Rebasing periodically so that a Provider shall not have its Basic per Diem and Per Discharge Rates calculated by reference to the same Base Year for more than eight state fiscal years; provided, however, that the duty to Rebase shall be suspended during the period that the 1115 research and demonstration waiver is in existence and for one state fiscal year thereafter.

C. REQUESTS FOR RATE RECONSIDERATION

1. Acute care providers shall have the right to request a rate reconsideration if one of the following conditions has occurred since the Base Year:

a. Extraordinary circumstances, including but not limited to acts of God, changes in life and safety code requirements, changes in Licensure law, rules or regulations, significant changes in case mix or the nature of service, or addition or new services occurring subsequent to the Base Year. Mere inflation of costs, absent extraordinary circumstances, shall not be grounds for rate reconsideration.

b. Reduction in Medicaid average length of stay within a facility which produced a decrease in the average cost per discharge but an increase in the average cost per day. This paragraph shall not include reductions in average length of stay resulting from a change in case mix. The rate reconsideration